STATE OF CALIFORNIA

MANAGED HEALTH CARE IMPROVEMENT TASK FORCE

PUBLIC HEARING

2:15 P.M.

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California Chamber of Commerce Building

1201 K Street

12th Floor, California Room

Sacramento, California 95814

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SACRAMENTO, CALIFORNIA; SATURDAY, JULY 26, 1997

2:15 P.M.

CHAIRMAN ENTHOVEN: The hearing is now open to the general public. Let me just restate as I did moments ago, please be sure that you have a speaker card up here so that if you want us to know who are. And we will be taking them in the order that we receive them. We're going to start by scheduling each person to speak for five minutes, and then we will allow five minutes for questioning by the task force.

I'm going to have to be a little brutal in the interest of getting through all this. So I'll ask you, for example, if you have a lengthy prepared statement, you can file it with us. For the record, we'll read it, and if you just hit the highlights. I think it's more effective to present if you really give us the highlights and bottom line points that you want us to take home and then interact with the task force.

And as I said before, our focus is really on systems improvement. We are aware that there are a very large number of quality access problems with the health care system. So anecdotes reinforcing that won't point us in a helpful direction. What we really need are insights into how can the system be redesigned and who might do that in order to make this all work for people. So I'll start with Kit Costello, the California Nurse's Association.

MS. COSTELLO: I actually did bring enough

copies of my testimony, if you'd like to have those passed out and add them into the record.

CHAIRMAN ENTHOVEN: Fine.

MS. COSTELLO: I really appreciate the opportunity to be here today. I'm president of the California Nurse's Association. And as I said, I've submitted my written comments for the record. But I would just like to hit some of the high points of recommendations that were making as an organization.

First of all, the questions that were used to guide the public in their comments, I obviously -- I had some disagreement with the notion that we actually operate in the health care marketplace, because many of us have to take what's offered by our employer and I'll just offer it as an example.

Kaiser nurses that work for the Kaiser system are offered for choice of health insurance a very poor indemnity plan or the Kaiser health plan. So the notion of having a marketplace is really not very operational for us. And so I'd like to focus my testimony on some categories.

Protecting patient's rights, protecting health care professionals, patient advocacy obligations, and regulating standards for safe care. One of the things that we support is legislative mandates that would create a standard of 90 percent or greater of premium revenue that would have to be spent on patient care.

And I offer an example of U.S. health care

who spends as little as 75 percent of their premiums on care, and at the same time, during their last merger paid CEO a buy-out in cash and stopped the compensation of close to 1 billion dollars. So we believe there is a relationship.

I would also like to say that we would support some sort of debate on whether risk adjusting capitation payments might encourage health plans not to shun the sick. And it would also help, we think, with the Medicare fund in terms of the overpayments that have received a lot of notoriety of late.

Also, we support full disclosure of medical information to patients. There has been a lot of gag order legislation passed recently. We think it needs to be followed up on and enforced to prevent against abuses.

We also believe that bonuses and incentive compensation arrangements do affect clinical decisions. And just about any provider will confidentially tell you that their decisions are affected by the method in which they're compensated. Therefore, we believe that there must be a complete band on any bonuses, incentives, or penalties that would have a direct or indirect affect on health care decisions.

We also favor the legislation of whistle blower protection that would prevent managed care plans and health care employers from discharging, demoting, or terminating, denying privileges to health care professionals who advocated on behalf of their patients.

We also support in the interest of the attempt to create a marketplace in health care that written criteria for denial of care be available to patients. We think it's very important that the DOC take a role in this by mandating specifically excluded benefits, treatments, et cetera, from health plans, and publishing a comparison for the public so that people could actually make decisions regarding the choice of a health plan. And we also believe included in this should be a description of the grievance procedure for the various plans.

We also support examination by a qualified health care professional before care is denied, if there is a challenge to the denial. We also believe -- and this is something that is very dear to us as nurses -- that quality hospital care and staffing levels and health facilities need to be better regulated. We've seen the effect in the last five years in managed care reimbursement reductions for hospital care, feeling shorter length of stay, shorter recovery periods for our patients.

And in turn hospitals have turned around and reduced the numbers and skill levels of staff that talk care of those patients. So what we have essentially are sicker groups of patients with reductions in staff, reductions in the skill level, and numbers of registered nurses and others caring for those patients.

I have, if anybody is interested, a report

that we have developed to support --

Is my time up?

CHAIRMAN ENTHOVEN: Yes. Thank you very much. And we will read your report. Questions from the task force? Any comments or questions? Anything else?

All right. Thank you very much.

MS. O'SULLIVAN: I have a question. On the disclosure of criteria, what would that look like? What would -- what are you envisioning a patient would see? What kind of information would a patient get?

MS. COSTELLO: For example on quality disclosure, I think it's important to understand that both health plans and hospitals maintain large sets of data that they use for their business decisions that we never see as public.

For example, if you contact with the health plan, you don't know whether the hospital in turn subcontracted hospital care for, for example, the medication error rates, what the rates are for hospital acquired infections, postoperative wound infections, medication errors, falls, bed sores. All that is kept, but we don't know it. So that type of information is available. It's just not submitted, analyzed, and presented for our review.

MS. O'SULLIVAN: Actually, referring to criteria for denial of care, though, is that different what a patient would understand in terms of what they would be apprised --

MS. COSTELLO: Well, for example, I think the issue of bone marrow transplant for late stage breast cancer, what's the criteria upon which they would deny a woman with a late stage breast cancer bone marrow transplant? I mean, if you have a family history, I would assume you would be very interested in knowing that. I know I would.

CHAIRMAN ENTHOVEN: Clark?

MR. KERR: So you would favor on having the information on infections and adverse drug events so forth from the hospital?

MS. COSTELLO: I would. Some of it has been collected, but with the understanding that the hospital's identity would remain secret. For example, the Maryland Hospital Data Information Data Set. A lot of indicators were collected.

MR. KERR: Should it be kept from the public?

MS. COSTELLO: No, I don't think it should be. I think we have a better chance of picking out a vacuum cleaner than we do a health plan that contracts with a hospital that has quality care.

CHAIRMAN ENTHOVEN: Are you comfortable that the required reporting wouldn't feed back into incentives to not report and to cover up and --

MS. COSTELLO: I think in order to guard against that, there would have to be a regulatory mandate to go in and do audits to make sure that the data was

clean.

CHAIRMAN ENTHOVEN: Mark.

MR. HIEPLER: Is there any list of the top couple things you think managed care is doing to affect nurses good, bad, or indifferent that you're experiencing just being out in the forefront?

MS. COSTELLO: I would have to say, for example, within Kaiser there is a big push to substitute lesser trained personnel at all levels for licensed personnel. I know in the advice centers now for the adult advice calls, when they come into Kaiser, it used to be a registered nurse would be the -- the gate keeper would answer the calls.

Now we have appointment clerks and medical assistants taking information, determining whether the nurse should then become involved to give advice based on symptomatic reporting of patients. I think it's backward, and we had some problems with it.

Plus a lot of time, there's a large turn around time from the point where the call is answered, a message is generated, and a nurse calls back to get more information and do a disposition. Sometimes four or five hours. So a lot of delays.

CHAIRMAN ENTHOVEN: Harry.

MR. CHRISTIE: Based on the fact that a lot of the length of stays in the hospitals are being reduced by managed care, do you feel that some form of an informed consent is required before a patient is discharged to

advise them of the potential risks of an otherwise early discharge?

MS. COSTELLO: I think that what would be helpful is -- for example, what's happening now that's fueling a lot of those early discharges is the development of clinical pathways. So you take, for example, you know, a surgical intervention. And there's a standard for length of stay that's prescribed by the clinical pathway. And there's a lot of push to fit your clinical judgment within that pathway.

But an elderly woman with chronic anemia who's diabetic is not going to recover as quickly from a hip surgery as a healthier person at the same age. There's just too much of fitting ill people into well people's standards around these length of stay protocols. It's a real problem. And teaching isn't happening, either, especially with maternal and child issues.

What we're finding is nurses are complaining about taking a lot of, for example, breast feeding phone calls on the advice lines from fresh mothers who have just been discharged. They should have been comfortable when they went home with infant feeding and care.

CHAIRMAN ENTHOVEN: Thank you very much. Our next speaker, presenter will be Jane Parish from the Breast Cancer Advocate.

MS. PARISH: Good afternoon. I'm here to put a human face on this. I don't have all the statistics. I'm a nine-year survivor of breast cancer,

and I'm a breast cancer advocate. I work on my own. I've advocated for hundreds of women for eight years. I'm right there on the trenches, on the front lines seeing how the patients are treated through their different treating physicians and their insurance companies.

I don't accept any compensation or no consideration for what I do. So I have no axe to grind or no vested interest other than the interest of the women I'm advocating for.

I had breast cancer in 1988 and was a Kaiser patient. And I became aware -- acutely aware of the shortcomings of managed care in 1988. It became apparent to me that my options of care and access to physicians were extremely restricted.

In 1988, it was very difficult to obtain updated information concerning all options of care. The information resources that were available at that time included State of California pamphlet on breast cancer, which was required by law, the American Cancer Society, and the public library.

Obviously, I didn't feel fully informed as a breast cancer patient. It became apparent to me that if women are provided information on all treatment options, they will make a fully-informed decision. Unfortunately, very few cancer patients have the option of having an advocate.

Nine years later, being 1997, breast cancer patients are still scrambling on their own to become fully

informed and still have limited access. I'm going to give you one example that I'm currently working on so it's very fresh in my mind regarding what I would call limited access. And this regards breast reconstruction after mastectomy.

In 1997, you'll have approximately 180,000 diagnosed cases of breast cancer in the United States. Of those cases, you'll have approximately 9,000 mastectomies. And of those 90,000, you'll have approximately 30,000 that will be reconstructed. That number would seem pretty low. It's obvious to me that a woman -- it would not be a woman's first choice to live a life with one breast.

Better methods of breast reconstruction are available. They have been practiced for years, but they have not been promoted to the public. Why is this? Pamphlets from the American Cancer Society where many women go to get their information after being diagnosed did not make reference to these cosmetically improved techniques. Instead techniques of breast reconstruction are typically presented that show mediocre results from outdated procedures.

Obviously it would not benefit the bottom line of managed care insurance to increase this percentage of women choosing breast and reconstruction due to cosmetic results. Furthermore, a big concern is that women fearing deformity may delay seeking early diagnosis and treatment, which is the most important component of a successful outcome.

Better methods of breast reconstruction have the potential for reducing this fear in convincing women to seek earlier rather than late treatment. This is particularly true in younger patients who are at greater risk due the aggressive nature of breast cancer.

Restricted access to health care by managed care insurance is achieved by several strategies; point of service and panel of physician restrictions force patients to seek treatment at a limited number of facilities by a limited number of physicians who are offering a limited number of option.

This is due in part to the protection of managed care insurance under ERISA. ERISA limits the liability of managed care insurers putting on the medical care. Reimbursement schemes such as capitation offer financial incentives to physicians to under treat. It is apparent that in many cases the best treatment in managed care is no treatment.

It is further apparent that legislation is required to protect the public from excesses of managed care insurers. Specifically, statutory prohibition is required for panel physicians and capitation schemes of reimbursement.

ERISA also needs to be seriously reviewed and rewritten to make managed care insurers accountable for their decisions. Isn't it remarkable that the insurance industry in general allows the insurer to make decisions concerning the restoration of their property

after sustaining an insurable loss? Don't you think that the health insurers should allow the same freedom of choices to restore the patient's health?

It has been managed care's argument that option should be restricted to, quote, protect the patient, unquote. This is a thinly veiled excuse to deny care for profit. The public has a right to demand and the government has the obligation to guarantee the same level of protection to women's health care as is currently provided for our homes and cars.

CHAIRMAN ENTHOVEN: Thank you very much. Questions from members of the task force.

MR. HIEPLER: Is there anything you see that's an impediment to patient care in the managed care HMO doctors that you're visiting?

MS. PARISH: Well, I would say the No. 1 facility -- I visited Kaiser facilities, and talking about one particular organization, I see a lot of leading of the patient, of giving one option, saying, "This is what you need to do, and this is what you need to do."

Also, their practice there for breast reconstruction -- basically, what their line is, "We don't believe you should be immediately reconstructed because of the risk of infection, and it's a lot to undergo." But actually, in reality, what it is, is that they have only one plastic surgeon, and they know that a certain number of women are going to choose not to be reconstructed after they've undergone mastectomy, undergone chemo, maybe

undergone radiation. So it does cut the number people down who would be choosing that option. I don't see that as prevalent with other health care providers.

CHAIRMAN ENTHOVEN: Barbara.

MS. DECKER: Maybe I didn't understand you exactly, but I wanted to clarify. You mentioned that the material, I think you were saying, many women seek when they have this diagnosis, frequently it comes from the American Cancer Society?

MS. PARISH: Right.

MS. DECKER: And then the material has apparently outdated information about reconstruction?

MS. PARISH: Well, I'll tell you, one week ago -- I've been working a lot on HR164, and Ash's Bill for breast reconstruction and making that a federal law for all states.

So I've done a lot of research on that. But, yes, it is outdated. I checked with them one week ago to see what their current literature had, but it's missing this particular procedure that leaves a woman basically unscarred. It's unbelievable surgery. And in his practice -- doctors do know about this, but never once have I heard this procedure mentioned in the Kaiser system, and rarely have I heard this procedure mentioned in other settings where I've been with a surgeon or plastic surgeon.

MS. DECKER: Has there been any particular source of information that is open to the public? In

other words, not your own investigation, but a broadly accessible source that you think does have good information?

MS. PARISH: Well, in the course of the past few years, with the computer's access through the internet, there is a lot of web sites out there, and there's the NCI, but a lot of -- I advocate for a lot of disadvantaged women. They don't have this access. So they go to your typical sources, which I say are the American Cancer Society, the public library. That's where they go looking. And of course, that material is not up to date. So they really have to count on their health care provider.

CHAIRMAN ENTHOVEN: Clark? Sorry. Bernard?

DR. ALPERT: For many reasons, personal and professional, I am quite sensitive to your testimony. I have a question about your advocacy.

Have you spent time in the hospitals when the patients are inpatients?

MS. PARISH: Yes, I have.

DR. ALPERT: And as such, there's been a number of different hospitals?

MS. PARISH: Yes.

DR. ALPERT: So would you give us an opinion relative to the previous testimony we just heard about nursing, staffing, and so forth, because you're there as a patient advocate, and we can kind of see and compare a number of different places.

Do you have a theme that agrees with the previous testifier or disagrees?

MS. PARISH: I agree 100 percent. I've seen it firsthand. I had a woman who was by herself. She was a Kaiser patient, Kaiser Walnutcreek. And she didn't have any family at all, no support. She was on public assistance.

And she had gone in for a lymph node dissection as well as lymphectomy under general anesthetic. She was in -- I had talked to her before about her wishes. Did she want to stay. And she said, "Yes. I have no care. I have no one home. I'd like to be able to spend the night." I knew what her wishes were. She came into recovery. She was not conscious. She was still under anesthetic, and the nurse came in and said that she had been signed out by the treating physician. And I said, "Well this woman is not conscious. What do you intend to do?"

And she said, "We can call a cab for her as soon as she's conscious enough."

And I said, "That's not her wishes."

And they said, "I'm sorry. The doctor signed her out."

So what happened was I told her, "Either you admit your patient or I don't leave." They all know who I am, and they admitted her. And I waited until she got in the bed.

But that's probably getting more common

because if you'll look at information, I think it was given to you about me, I do a lot of picketing. And I picketed Kaiser because of their policy of releasing mastectomies in one day. They got them out of there. It's like in and out under general anesthetic. So it's still going on. There are some hospitals that -- I've been in some settings that I feel were definitely superior.

CHAIRMAN ENTHOVEN: Last one. Anthony Rodgers.

MR. RODGERS: I'd like to get into one of the issues you brought up, which was the fact that information is being either omitted or not provided to the patients.

Do you think the motivation is cost or is it just that the procedures are new and taking time to get into the use by physicians and professionals?

MS. PARISH: It's cost.

MR. RODGERS: It's cost?

MS. PARISH: I don't think. I know it's cost.

MR. RODGERS: So the particular procedure you're referring to is more expensive, and therefore --

MS. PARISH: Well, it's not that it's more expensive. It's that you would have more women choosing it. When you have a woman in a setting in a plastic surgeon's office, and she's seeing horrendous pictures of breast reconstructions with scars all over, you're talking

about tram flaps that are basically moving muscle up from your stomach, six-hour procedure, high risk of infection, you're going to have a certain number of women say, "I've already undergone enough. I'm not going to do this."

But if you could see those other results of an option that's out there, you're going to have more women chose it. managed care doesn't want more women choosing reconstruction. They want to keep that number down to 30,000.

CHAIRMAN ENTHOVEN: Thank you. Our next presenter will be Loren Johnson, M.D. California Chapter of the American College of Emergency Physicians.

DR. ALPERT: While he's coming, I have a one-line answer to the question. The procedure to which she's referring has been around since the late '70s.

CHAIRMAN ENTHOVEN: Dr. Johnson.

MR. JOHNSON: Mr. Enthoven, distinguished panelists, I represent 2,000 emergency doctors here in California for the California Chapter of American College of Emergency Physicians. We're the ultimate safety net that everybody keeps referring to as the inappropriate use. You know that one. The emergency room.

If you will, that is the exact dilemma of emergency services in California under managed care, and that is the tendency to take for granite a community service system, in essence, a public service that has its roots in public service going all the way back to the inception of emergency medicine, and sort of assuming that

it's always going to be there for you, especially under the competitive business model of managed care.

Now, it is true that the Emergency Medicine Treatment Labor Act of the late '80s has created a system of mandated services by hospitals and by emergency physicians nationwide. And this is certainly a great boom to the consumer and to the public and has, to a certain extent, strengthened the safety net.

However, it's a non-funded mandate. In essence, it's mandated benefit -- a mandated service without mandated benefits. There was never link to insurance coverage. So as we saw managed care unfold in California, we saw four systems planning. We saw examples like the GNC project here in Sacramento with 150,000 covered lives suddenly having the funding redirected for the provision of intense episodic care, but not redirecting the patients.

They still came to the emergency department, and they became COBRA violations and TALMA violations in our care, wherein they were defacto of COBRA violations of over 100 fold increased enrollment rate for Medi-cal patients over and above commercial managed care patients because of shady gate keeping.

And also, the result of unfair business practices. We've seen very poor control of the -- of the Medi-Cal managed care intermediaries by the Department of Health Services to the extent that there's -- the payment performance of many of these contracting plans has been

scandalous largely because, again, it's so easy to gain the system. It's a mandatory service without mandatory benefits.

So we saw considerable infrastructure damage. We saw our backup for our specialty panelists resigning in droves. Again, something we all take for granite. Doctors cover emergency rooms; right? It's sort of quasi under the hospital requirement of COBRA and TALMA, but not necessarily if they resign from the medical staff or find ways to squeeze out of it.

So just the assumption that you can go into any emergency room and into any community in this state or in this nation and always get the care you need and particularly the specialty emergency care you need is an enormous, not necessarily valid assumption. There's infrastructure damage and all our specialists are resigning in droves.

This is what happened with the chaos of sudden thrusts of the business model on top of a community service model.

Now, we survived this, and basically survived it by going after consumer protections to link mandated benefits. We got the Ferguson Act here in California in 1995. We're going for the Carden Act nationally. The Access to Emergency Medical Services Act which would link a prudent layperson's standard for emergency utilization to insurance coverage and would require that it be provided at least to screen emergencies

and to stabilize patients who have emergencies on a nationwide basis with no prior authorization.

In other words, direct access -- not necessarily payment for non-emergencies, but direct access at least to be screened and evaluated. So this has become sort of the Holy Grail in salvation of emergency medicine in the EMS system, if you will.

Now what's gone on since then is obviously we had to reinvent ourselves to live within the business model of managed care. I want to submit we've done that. We've got written testimony that will be available for you in Los Angeles. And we have specific recommendations for how to save the public service model of health care within the business model of health care. And with that, I would invite any questions.

CHAIRMAN ENTHOVEN: Thank you very much. Brad Gilbert.

DR. GILBERT: I think you raised a very good point, which is the discontinuity between the community's desire to have trauma centers and centers capable of providing emergency care for those who need it in terms of emergency care.

But how do you suggest you deal with the juxtaposition of individuals accessing ER care when it's really not appropriate? When they would be better served by a primary care physician or an urgent care setting? I agree with you that there needs to be this safety net, but I don't agree that there should be open access that allows

emergency rooms to be used inappropriately, both from a medical care standpoint and the business standpoint.

How would you suggest some strategies to deal with that juxtaposition?

MR. JOHNSON: Well, certainly, we need better definitions for risk stratification and presentational acuity in terms of what constitutes emergency visits. And I would say that we're working intensively on that.

However, you also need to think in terms of the fact that the emergency departments of this country are in many respects an unused resource. Yes, they've been -- everybody's trying to carve out and steer away from the emergency department use because it's been high cost. No. It's high charge. Hospitals have been cost shifting onto those services.

And, in fact, we're exploring lots of models with hospitals right now to reduce the charge of unitary pricing and so forth for ambulatory -- for episodic ambulatory care. There's no reason why our unused capacity can't be put to use in a more efficient economic sense. And in fact, we're the hub of acute care in communities. We in essence network and interact with every aspect of the community service network. So we are the ultimate managed care integrator.

CHAIRMAN ENTHOVEN: Mark Hiepler.

MR. HIEPLER: I've heard a lot of discussion among emergency room physicians about the inability to get

the approval; you're trying to deal with emergency situation, and you've got to call the 800 number and so on.

Can you describe in your organization or in your own practice if that's been a problem and any remedy that you would see for that?

MR. JOHNSON: Yes. That's prior authorization, on-site authorization when the patient gets there, and that's illegal under new HCFA regulations. And I submit to you that that will go away in California in the near future, and we intend to make that promise.

In essence, every patient who presents to the emergency department will get -- will get an emergency evaluation without economic coercion and in a timely manner. And that's one our fundamental missions, is to be able to provide that service as a service to communities.

It's been a serious problem. I'd be happy to -- I think we'll be able to reflect more on that if some of our members may have an opportunity to testify in Los Angeles. Yes, we've seen surrogate gate keeping by unqualified people from outside the community that don't have a clue. I've had -- I've had an IPA here in town, in Sacramento, and I've been practicing in Sacramento for many years, instruct their members to deny authorization because the emergency room has to -- in a memo form -- because the emergency room has to take care of them anyway. And we can save a million dollars.

I've had denials of patients on spine boards

from freeway rollovers, patients with arterial bleeders in emergency departments. That will not stand and we will not submit to it.

(Applause.)

MR. HIEPLER: That is a problem, even though it's illegal.

MR. JOHNSON: It is a problem, and it's going to go away. It's the dominant market practice. We surveyed 23 out of 43 hospitals in Orange County, and they still play Mother May I for emergency services.

CHAIRMAN ENTHOVEN: Steve Zatkin, are you going to talk about the treating between the Kaiser program and the emergency physicians? Is that what you're going to ask him about?

MR. ZATKIN: No. We are supporting the same bill, but you did indicate that under current California law, those provisions are illegal -- I mean, those practices are illegal, you were referring to.

MR. JOHNSON: It's actually under federal law, and --

MR. ZATKIN: Under California law it's legal?

MR. JOHNSON: No. But it's true under federal law. And the recent HCFA regulatory practice that the practice of prior authorization and informing the patient of the denial is considered economic coercion from obtaining emergency care.

The Ferguson Act actually has a broader

standard for emergency services, but pretty much fits with this prudent layperson's standard. In essence, a common sense standard for what the consumer thinks might -- would be a possible emergency.

The dilemma, of course, if you go in -- if you go in with chest pain and come out with a diagnosis of dyspepsia and the plan denies payment for the service, then obvious the consumer needs to have his potential heart attack evaluated. And that's an emergency service. So that the dilemma is the difference between a perceived emergency and a real emergency and what gets paid for. We think that common sense perceived emergencies and their evaluation needs to be covered.

MR. ZATKIN: All right. I don't disagree. I'm just trying to clarify what the state of the law is in California now.

MR. JOHNSON: The state of the law in California is actually a little more far reaching than the prudent layperson standard, but grants exceptions to Kaiser for a specific reason that Kaiser has an excellent post-stabilization case management system called the Emergency Prospective Review System that operates statewide. That was the ostensible reason why Kaiser got the waiver on that one.

And in essence, right now we've got a bill that excludes that in contract situations, and we don't think that should be excluded. That's the Morrow Bill 682 in the current session. We want to eliminate that.

CHAIRMAN ENTHOVEN: Ellen Severoni. Last one.

MS. SEVERONI: Just one quick question. Can you get us the data that would back up what you're saying about high charge versus high cost? Because I would be really interested in that.

MR. JOHNSON: Yes, I can. There's a recent journal publication on that issue.

CHAIRMAN ENTHOVEN: Okay. Our next speaker will be Dr. Bill Weil, M.D., from Maxicare.

DR. WEIL: Thank you very much. And before you start the clock on me, I'd just like to say a personal thing. It's a pleasure to appear before Dr. Enthoven, who many of us considered the following managed care -- twenty years ago when I was in private fee-for-service practice, we considered you a certifiable nut. And now we consider you a certifiable genius. One of us has changed his point of view.

CHAIRMAN ENTHOVEN: I just want to say, my contribution wasn't managed care. It was what started years earlier. It was called managed competition, which was to lay out a framework of the rules under which they would have to compete. Rules like what Marcus Stanley described, standardized benefits, information reporting, et cetera.

We won't take that out of your time. But at least you can start the clock. The whole idea was an affirmation that -- for this market to work, there have to

be rules.

DR. NORTHWAY: You better watch out. He might change his mind.

DR. WEIL: I live by those rules. In fact, I'm here to say something nice about managed care. I know that you heard nothing but anecdotes for the last few times you've met. But I'm here to talk about what one of the world's leading experts on health care said this morning. "Does managed care suck?" It only depends on your point of view.

If you are a fee-for-service private practice physician, then you really think it does. If you are a consumer who is part of the managed care world, then there are advantages to managed care that never appear on that other side of the fee-for-service private practice. It starts with credentialing. Every physician who's part of managed care is thoroughly credentialed, something that does not occur at all in the fee-for-service and dependent side.

As a matter of fact, the Medical Board of California tells us there are probably 2,000 people practicing medicine that have no license. That would never occur to managed care where the license is updated everyday two years, where the DEA certificates are looked at, where education and Board certification are very important, where there is recredentialing, which not only reaffirms all those necessities, but looks at things that occurred in the past few years in malpractice suits,

complaints about UR, CQI complaints or member service complaints.

The second thing is utilization review. Utilization review is something that does not occur in the fee-for-service solo or non-managed care side. Utilization review makes sure that the patient gets the appropriate level of care. And one of the things that was discussed as one of the previous speakers said, nobody is discharged unless they're discharged with a discharge plan.

At least while I happen to be representing Maxicare, I am from Cedars-Sinai. I'm the medical director of Cedars-Sinai. We do not let anybody out of the hospital unless there's a follow-up plan, whether they go to ECF or home health care, so that the better plans, I'm sure, utilization review includes follow-up hospital care.

We also make sure there's not under utilization. We do that by looking at patient or doctor complaints when they think the patient is not getting what they should have, member surveys, satisfaction, family complaints, nursing staffing complaints, or a list of diagnoses called sentinel diagnoses.

These sentinel diagnoses are diagnosis for which a patient is admitted and you wonder whether they've had a problem with their out-patient care, such as a diabetic and ketoacidosis. Were they filed correctly for their blood sugars? Were they getting the appropriate

amount of insulin? Someone with cervical cancer, did they have a pap smear? These kinds of things are going to make sure there is not under utilization.

And then member services. There's no such thing in the fee-for-service private practice of member services. You don't like the doctor, you walk. But in HMOs and PPOs and in IPAs and groups, there -- since everybody is basically the same, they try and distinguish themselves by the service they render so that the patient has somewhere to go when they have a problem to complain. They can even go to the HMO and file a formal grievance. There can be binding arbitration.

But there's a whole cadre of people that try to solve the problems the patient has, which is something that is completely absent on the other side. CQI, Continuous Quality Improvement, they look at utilization, review the complaints, satisfaction surveys, they access audits to make sure that all those quality indicators are something that they can point to, especially if they're trying to attract business and to show they are rendering a high quality of care. Nobody does that in the fee-for-service independent practice.

And finally health education. Sure a lot of HMOs and groups and IPAs use it as an advertising feature, but health education is prominent everywhere, because most people want to empower the patient to be part of the team making the diagnostics and therapeutic resolutions.

And finally physician education. Take

Cedars, for instance. I have 80 primary care physicians that are interns. If they see a wart with padding, "My God, a wart. We got to refer it." There's a lot of physician education needed to make good primary care physicians out of physicians who are not trained that way.

Those are some of the things that are positive about managed care. Some of the things that I hope you will see are the checks and balances and the safeguards meaning that managed care isn't such a horrible thing after all.

I know your commission has entirely improved managed care. And I think there's plenty of room for improvement. But, you know, it ain't so bad to start with. So that was the message I was bringing to you.

CHAIRMAN ENTHOVEN: Thank you, Dr. Weil.

Questions? Dr. Alpert.

DR. ALPERT: I'm puzzled by one, your prior discussion, particularly the prideful dissertation with regard to the quality and credentialing process.

I would assume by that that you would then both encourage and welcome the most qualified providers, physicians in any area most qualified by broadly accepted means in terms of people who have risen to the heights in the field and all the procedures, had the most experience, publications, so forth and so on.

If that's the case, then why are we seeing people who fit the description I just said in term of quality being denied access to panels?

DR. WEIL: Some people are denied access to panels when the panels are too large. For instance, at Cedars, if you have -- we have like 12,000 people in the IPA with 340 doctors in the HMO panel. They're not going to make very much money in it. If a physician has five, six, seven percent of his practice that's managed care and the rest private practice, they have a tendency to treat those people differently.

So sometimes there has to be a necessary number of people who take care of a reasonable number of patients on a panel. Only when the physician has -- when at least 30 percent of his patients are managed care will his whole mode of practice be directed toward managed care. But I hate to see people treated differently, and that does happen until there's a significant number.

CHAIRMAN ENTHOVEN: Mark Hiepler.

MR. HIEPLER: Doctor, you indicated that physicians will treat managed care parents different than other -- than fee-for-service or PPO.

Did I understand that right?

DR. WEIL: Sometimes.

MR. HIEPLER: And is that because of capitated versus the fee-for-services system generally?

DR. WEIL: At Cedars, we pay our specialists fee-for-service, but we do capitate our primary care physicians. That's where a lot of complaints come. We find that our primary care physicians have a high referral rate. And I think when they have a managed care patient,

they triage.

MR. HIEPLER: So there is a concern that patients in a managed care setting, because of the financial system, can be treated differently than those in a fee-for-service?

DR. WEIL: That's why we have a very active member service department trying to prevent that, yes.

MR. HIEPLER: Does Maxicare, because of that concern -- and I think it's a very positive thing. Because of that concern, does Maxicare describe to its members how the physicians are paid?

DR. WEIL: I don't think that Maxicare tells them specifically how they're paid because many full-risk groups, like Cedars, can pay the physicians they want to so that at Cedars we capitate our primary care physicians and pay our specialists a fee-for-service. We are going to be capitating some of our specialists, which is probably a better way to do that than to get a fee-for-service.

Because of the differences that exist in the provider community, I don't think that Maxicare as an HMO could tell its members how their physicians are going to be paid. The physician groups and IPAs could.

MR. HIEPLER: So you think -- it seems as if what you said in the chronology that it is an important thing that physicians sometimes, at least in your experience, will treat you differently. Don't you think that's an important thing that patients should know then

so they themselves can police that they're are one or two physicians that might treat them differently because of the way they're paid?

DR. WEIL: Absolutely. I think you made a very wise observation, and I think it's very important that a patient know that so they know how to, quote, play the game to make sure that they get the proper care; that member service isn't available if they feel that they've been discriminated against.

CHAIRMAN ENTHOVEN: Clark Kerr.

MR. KERR: Just a quick question. So you're no longer with Maxicare. You're from Cedars; right?

DR. WEIL: We are a Maxicare provider group. That's why Peter Augden asked me to testify for Maxicare. But I am with the provider group. I am with Cedars. We have a contract with a variety of HMOs. Maxicare is just one of the ones we have contracts with.

MR. KERR: So when you talked about a number of the -- potential of managed care, do you -- when you look at your crystal ball, as a hospital person, do you see any concerns?

DR. WEIL: Yes. I certainly do. One of the concerns -- when had the I pleasure of being on your commission, we used to look at mergers and acquisitions. And it's hard to keep track without a score card anymore who the hell is who. And everybody seems to be changing to fee-for-profit organization.

Well, if you're a for-profit organization,

you have to show a profit. And I'm concerned that the money that's available for health care is going to be -- the for-profit is going to be taken off the top. And pretty soon they're going to squeeze physicians and patients so that quality of care will start to be affected.

I would think -- I would -- like, maybe your group could say that a medical loss ratio should be limited to 80, 85 percent, because there are some organizations with medical loss ratios of 69 percent. If anything is for profit, then it better show profits. It's there on the stock exchange. And that profit -- we're not the guys making the 3 to 6, 11 million dollars in salaries, which are public record of some CEOs of these organizations.

So the money is coming from someplace. I think it's terrible when a guy can get up to bat in major leagues in two games and make more money than the average physician in the United States makes. Something is wrong.

CHAIRMAN ENTHOVEN: Dr. Karpf.

DR. KARPF: We've heard a lot anecdotally both for and against managed care. There is a body of literature out there that does speak to some of the issues of outcomes under different systems of care. And also it speaks to satisfaction levels. I would assume that we could reassure the public, we will not actually take a look at that as a group in an organized fashion in a future meeting, but I think we will see there are

positives and negatives. And what we really need to do is understand how we evaluate that data and have we accumulate the future data so we can in fact see what is working and what isn't working.

CHAIRMAN ENTHOVEN: Right. Two things about that. First, in the last meeting we did a have presentation by Dr. Arthur Miller of U.C. San Francisco, Institute of Health Policy Studies of the Loft Miller Pair, that have been kind of a deans of literature reviewing in these comparison studies. And so Dr. Miller did present to us on that.

Any of the previous articles in 1994 said HMOs are as good or better. This time he's more -- well, the score looks like it's about even. There's variations on both sides. But we will continue to look at that. And of course, all the work that Clark Kerr has described on information reporting, quality monitoring is a very important part of that.

And of course, one of the things about managed care, it gives you a framework and really somebody to hold responsible who has to do the measuring and reporting.

DR. WEIL: I just want to say some articles in general show that; that care is equal regardless of work.

CHAIRMAN ENTHOVEN: Yes. Miller Loft did, right.

DR. WEIL: Thank you very much.

CHAIRMAN ENTHOVEN: Thank you. All right. Our next speaker will be Lynnie Morgan, a consumer from Concord, California.

DR. ALPERT: One thing about Dr. Miller's presentation, simply to be complete in the summary, there was a lot of discussion about internally forming, which is perversed payment incentives. I don't bring it up as a bad thing, but --

CHAIRMAN ENTHOVEN: Yeah. Just to make sure we understood, the point he was making was the lack of risk adjusted premiums; right? Which I think we're all agreeing is something -- I trust we'll be able to build a consensus for recommending.

All right. Ms. Morgan.

MS. MORGAN: Hi. I am a parent and I am a consumer, but I also am the founder and director of the Mitochondrial Disorders Foundation of America. I have sent information out to over 1,000 people in the United States and have clients here in California, so I think about this being in their benefit also.

I sent you a letter dated July 21, actually, and make reference to that letter today. But before I do that, I wanted to tell you that we all know for any organization to be a success, it has to have certain structure. And if you will kind of imagine a pyramid with the meaning -- well, we have to have needs. We've established that people have needs. We're not born to live an eternity. We are finite creatures. So health

care is a basic need that we all have.

So with that established, that means we have a need. We have to take care of those people somehow, each other somehow. So if you can imagine a pyramid with the top third of it being meaning, and the middle third of it being structured, and the bottom third being action, that's a good prescription for success, but the only thing that's missing is the care, caring part of that.

I took a Cal State Hayward course recently where the professor showed us how these things all worked together. And without the caring, you don't have -- it's not necessary for you to have -- there's no meaning for it if you don't care about something. There's no need for structure, and you won't have to have any action, because you really don't care.

And the reason that I bring that up is that in the health care system that's currently going, currently in action right now, I think what we have done is we had doctors who took an oath to care and serve the patient. And after attending last month's -- the last session of this task force, I went home and wrote down my observations and recommendations in this letter, because as I recall, that's what you asked for, observations and recommendations.

So one of the things that I would point out is that the administration must care. It must filter down to the doctors who must care. And the patients who must know that they are cared for, or the system won't work.

One of the things I'm wondering is if we remove the incentives and capitation, if those doctors will come back to caring again and the administration will be able to care.

I know that we -- you know, the incentive is something that's worked in the past few years. People are starting to grumble about that, and with good reason. For one thing, this thing that Mr. Romero gave out this morning, I think it's very interesting that he talks about job owning. And the first five things on this list really, to me, talk about how great the need is in California.

The amount of complaints that there are have risen in the last year. Why is that? Why do we have a task force? Because the need is just so great. There are a lot of anecdotal situations. But they are only anecdotal one on one, one at a time. But when you see a room full of people sharing those situations with you, when you see a governor who has to assign a task force, they become not anecdotal. They become an issue.

I think that if we look at the system, we work on incentives, removing incentives, or working incentives elsewhere, and possibly maybe focus on developing centers of excellence so that the health maintenance organizations and the fee-for-services don't have to be all-in-all to everybody. They can't afford to be all-in-all to everybody. That's one of the problems.

My daughter can't get a diagnosis because my

HMO is saying that they are specialists in that area when, in fact, they are not. So what is the problem? Our vulnerable wind up not being heard. Our vulnerable wind up not being served. And we have greater needs and a need for a task force. I would suggest that in the statistics, when we do our surveys, that the questions are relevant.

Questions like, "Are 15 minutes with your doctor adequate time to discuss your needs with him? Do you have your doctor's individual attention when he's in the room? And are you afraid to ask questions about your health care provider for fear of losing your insurance?"

I said this at the last meeting, and I'll say it again. Surveys and data is only as good as the questions that they ask. And I applaud your discussion earlier in the questions of the gal who had the question about are we really going to talk to those people on the phone. We're spending all this money on the survey. Is it really going to meet the people's needs? I don't think so.

Thank you for letting me come. And, please, if you have any questions about my letter, I'd be happy to entertain those questions.

CHAIRMAN ENTHOVEN: Thank you. Questions? All right. Thank you very much.

Our next presenter will be Maria Joelson of the California Nurse's Association. Is she here?

UNIDENTIFIED SPEAKER: She may have left.

CHAIRMAN ENTHOVEN: Okay. We exhausted her patience. The next speaker will be Gail Oheda, Latino Coalition for a Healthy California.

UNIDENTIFIED SPEAKER: She left.

CHAIRMAN ENTHOVEN: Warren Leach, speaking for himself. Cupertino.

MR. LEACH: Professor Enthoven and distinguished members of the task force, I'm a 63-year-old diabetic. I've been a diabetic about 25 years. I'm also on medication for high blood pressure. Starting in February of '96 through March of '97, I had five strokes, the second of which put me in the Stanford Hospital.

I recall that quite vividly, because I didn't know I was having a stroke, and I called the doctor, and I said, "What do I do next, and he said you better get to a hospital." So I called the wife, and I drove halfway to Stanford to Sunnyvale, and she drove beyond to Stanford ER. I got in about 6 o'clock. I never got up to the hospital part until about 2:00 in the morning.

And apparently -- it is my strong belief they were waiting for authorization from the HMO which was FHP and wanted to be darn sure I was really having a stroke. And apparently, the type of stroke I had was called Cerebellum stroke. That's why I didn't recognize it at first because it wasn't left or right hand paralysis. I subsequently testified in SP977 regarding the medical board applying to all people involved in

health care decisions.

And as I recall, all the parties there, except myself, they said "no." And when the center piece said I'll give you an exemption, they still said no. So that's where the industry is coming from. Subsequent to the strokes, I had several heart attacks. The first one in Tahoe. Second one in Reno. I went to Barton Hospital Tahoe, Saint Mary's in Reno. And I changed HMOs in January.

Health Net made a decision to fly me up by air ambulance back to the Bay Area into Stanford. So there were three ambulance charges and their ambulance charge, and of course I was in three hospital facilities. Two of them ERs. So that particular incident is probably going to run over $50,000. And I really think that some preconditioning or premanagement of my medical problem would have prevented a lot of this. There was no ultrasound Doppler X rays until I hit the Saint Mary's hospital in Reno. There was INR protimes done for blood clotting until I got to Stanford on the second stroke.

And as far as post stroke situations, I wasn't told about quad canes. I wasn't told about walkers. They stuck me in an old folks home. I got out the next morning. The old folks home by the way was cited by the state for many violations, complaints, citations, and they changed their name I noticed after I was no longer at that facility.

So what I'm saying to you is that there

should be some preconditioning or premanagement situations of people with my health problems, and also as far as post incidences, there should be some after care that wasn't given to me, and it would have maybe lessened some of these bills. So that's briefly my statement. If anybody has any questions, please ask me.

CHAIRMAN ENTHOVEN: Thank you. Questions? Okay. Thank you very much.

MS. SEVERONI: I just want to thank you. I don't know the geography up here. I asked Clark. You drove a long way, I guess, to get here today.

MR. LEACH: Yeah. I didn't drive. She drove.

MS. SEVERONI: But you came a long way. What would be the one thing you would like to see changed about the system and what -- what would make today's drive worth while?

MR. LEACH: Well, capitation payments as I mentioned in the testimony should be outlawed or made a criminal offense. To me that capitation payment is really the crux of the whole problem. And that should be diminished or modified or something. Because I understand there's one lawsuit going around here in Sacramento where the doctors were scheduling too many appointments, and there's this capitation pressure that goes on in the whole industry.

I talked to some nurses, and they said they work 12-hour shifts. And how can you take care of

patients when you're working 12-hour shifts? So there's too much pressure put on the personnel. This profit angle I think has just gotten way out of wack. And it's got to be reigned in. And I followed the industry pretty close. I've got annual reports, 10K, and all these HMOs, and I see a lot of stuff in there that's really bad.

CHAIRMAN ENTHOVEN: Mark Hiepler.

MR. HIEPLER: Sir, before your situation and complications that you encountered, did you understand in your HMO how the physicians were paid?

MR. LEACH: No.

MR. HIEPLER: Okay. Do you think that would have helped you while you were in the emergency room if you had understood some of those things to advocate better for yourself?

MR. LEACH: I have too many things in my mind quite frankly, but we were in Kaiser at one time. We left them. We went Take Care. Take Care was bought out by FHP. And FHP was merged into Pacific. So it's very difficult to keep track of these plans as they're offered to you. I can't even get health insurance because I'm a diabetic. I got health insurance through her job. And like I said, these HMOs -- it's like Pacman. They just keep moving around.

MR. HIEPLER: Did they ever tell you why it took so long to get in the emergency room?

MR. LEACH: No. They had a CT scan. I was interviewed by a lot of nurses and emergency room

physicians and personnel. Like I said, it was 6 o'clock in the evening when I got there, and I didn't get in the hospital itself until about 2:00 in the morning.

CHAIRMAN ENTHOVEN: You mean you weren't admitted out of the emergency room into the --

MR. LEACH: Right.

CHAIRMAN ENTHOVEN: Do you have any good reason to believe that was because of the HMO as opposed to just it took all those nice Stanford doctors a while to get down there and do all the tests?

MR. LEACH: Well, I kind of walked -- I should say staggered into the ER. And I got up on a gurney, and I was there all that time. People just kept coming around interviewing me. I guess there was some question, "Is this guy really having a stroke or isn't he?" I already had a previous TIA in February. As a matter of fact, there were two TIAs according to the CT. One in the right hand side of the brain, took out the left side.

CHAIRMAN ENTHOVEN: What my question was directed at was: Is this ascribable to Stanford care or to the HMO?

DR. WEIL: Stanford care is up to speed. I had insisted on going to Stanford on the first stroke.

CHAIRMAN ENTHOVEN: Dr. Karpf.

DR. KARPF: I don't want you to take this the wrong way. Somebody must be doing something right in the health care system if you've had multiple strokes,

multiple heart attacks. And being as effective as you are as a speaker, something worked right someplace.

MR. LEACH: Well, my father is 93, and my mother is 90. So it's probably in the genes.

(Applause.)

CHAIRMAN ENTHOVEN: All right. Thank you. We're going to take a ten-minute break.

(Brief recess.)

CHAIRMAN ENTHOVEN: Will the meeting please come back to order.

Our next presenter is David Blackman. Mr. David Blackman of Tower Health.

Thank you for coming Mr. Blackman.

MR. BLACKMAN: Good afternoon. My name is David Blackman, I'm vice president, chief operating officer of Tower Health. Tower Health is a Knox-Keene licensed HMO in Southern California predominately serving the Medi-cal population.

I may not look like a traditional health care executive, and I certainly don't play one on TV, but I have worked on both sides of the fence that we're discussing. I've worked for physician billing organization and hospitals as well as 15 years in the managed care HMO side.

Eight years ago, my mother faced amputation of both of her legs, and she was a member of Kaiser Permanente, and amputation was discussed. My brother, who was not an advocate of managed care, felt that she needed

to get out of the hospital, and only a fee-for-service physician would do the right thing.

After many, many phone calls, he discovered that -- what many people told him was that the best vascular surgeon that they thought was at Kaiser. And we contacted this individual, and he accepted my mother as a patient and several days later did surgery to save her legs. But the surgery was unsuccessful.

Late that evening, the doctor contacted me and said, "I'm going to try one more thing. I've been up all night trying something else." The second surgery was also unsuccessful. So we discussed amputating of the legs. The next day the doctor came in and said, "I'm not giving up. I've got one more last try, and I want your permission to go ahead. I think that she can stand the surgery." He did the surgery. The surgery was successful and both of her legs were saved by a managed care physician who cared about the patient and who had compassion and quality in the forefront of his mind.

Today she has difficulty walking but nevertheless has both of her legs. I do not believe that it is simply an issue of what works and what doesn't. What systems to fix and what doesn't. I believe that the political and budgetary and other economic forces on health care in general are the result of the changes in managed care and changes in health care.

If this committee and the public at large will -- is going to judge the managed care industry as

well as the press based on anecdotal stories, I fervently and adamantly hope that both sides of the stories are listened to. I have worked on both sides of this proverbial fence, and I have seen what I believe to be good quality care and access in the managed care industry. And with that, I'll be happen to take any questions.

CHAIRMAN ENTHOVEN: Dr. Alpert?

DR. ALPERT: Do you have any specific recommendations for us to make to the government or the state with regard to managed care?

MR. BLACKMAN: Yes, I do. I think the issue of risk adjusted premiums that have been talked about is probably the paramount issue. I really sincerely believe that. As an example, a perfect example, the state is paying the same capitation premium for individuals on AIDS and HIV in the Medi-Cal program as they do for all other Medi-Cal individuals.

I'm a licensed and certificated counselor with HIV/AIDS patient. And I know that they have greater needs than just medical. They have social and economic and environmental needs as well. And yet my company as all other Medi-Cal subcontractors are getting $70 a month to treat an AIDS patient. I think that's an example, and I think risk-adjusted premiums are not the way to go.

DR. ALPERT: I just want to make sure I understand this. So you think the biggest problem is that the HMOs are not being paid enough for taking on high risk people?

MR. BLACKMAN: No. I'm sorry. Let me clarify that. I think the biggest problem -- I think the biggest problem is that there are sometimes intangible forces, systemic forces that include political, environmental, and budgetary at the state level that are exerting influence on the managed care industry and not the systems and the capitation system that has developed due to the changes in general in health care in this country.

CHAIRMAN ENTHOVEN: Any other questions? No comments? Okay. Thank you very much, Mr. Blackman.

Our next presenter will be Wilma Krebs, California Senior Coalition. Is Ms. Krebs here?

Thank you for coming. Please sit down.

MS. KREBS: I had a very simple question earlier on. And that was the comparison of the HMOs and the PPOs in the indemnity plans in which the PPOs came off, quote, badly, I think. And my question was about the sample, whether the PPOs, for example, included the PERS PPO, PERS care and PERS choice, which are perceived to be very high quality within PERS.

CHAIRMAN ENTHOVEN: My understanding is that survey was broad-based for PPOs, you know, PPOs across the state so that PERS would have been there to the extent of its statistical weight. But I'm not really sure of that.

MS. SHAUFFLER: It's only one PPO out of 20 or so. Whether it does isn't going to overwhelm what the majority do. But everything that we collect is

confidential; so I cannot reveal any information specific to any health plan. Otherwise, the health plans wouldn't respond to my survey.

CHAIRMAN ENTHOVEN: You raise an important point. Don't go away yet. Let's just carry this on for a minute. You put your finger on an important point, which I think we ought to draw out here, and that is that shot is called by the employer. So we're talking about the different coverage levels and, you know, let's say our mammograms covered this, that, and the other thing.

And so you ask about PERS. Well, PERS is the purchaser, and they can decide what to include in their coverage contract as they think best. So we shouldn't think of PPOs as freeflowing entities out there that are doing things on their own. The employer or the purchaser is calling the tune, and they're just dancing to that tune. I think what it reflects is that there are some employers who go for much less expensive coverage.

MS. KREBS: Thank you.

CHAIRMAN ENTHOVEN: Next. William Powers, Congress of California Seniors.

Mr. Powers.

MR. POWERS: Good afternoon. My name is William Powers. I'm here representing the Congress of California Seniors. We are the California arm of the National Counsel of Senior Citizens. We have an affiliate membership of over $500,000 in the state. Our advocacy is 100 percent volunteer. Adequate and universal health care

has been a major part of our agenda since our inception. the CCS was among the original sponsors of Proposition 186 to establish a single-payer health care system in California.

Unfortunately, that did not pass. We are proud to be a sponsor and supporter of the Patient Bills of Rights, which is winding it's way through the legislative process a couple blocks from here. We are strong supporters of the Patient Bill of Rights because of what we hear from our members and their concerns about the managed health care system. Most of our members are retirees, and a high percentage are in managed care.

The information provided at the hearing is on the 13 -- now, as I understand, it's 14 bills in the Patient Bill of Rights, as well as recent revelations in the media, we believe more than justifies the need for this important legislation. That is why many of the bills being are passed with bipartisan support.

We want to make it clear that the Patient Bill of Rights is a modest response to the rapid growth of the managed health care system and the problems for consumers which have resulted. These are not radical proposals, as some in the industry would have you believe, but measured responses to protect consumers and their health care needs.

Things like protecting the doctor/patient relationship, providing adequate information, protecting the free speech rights of consumers, and assuring

accountability are some of the issues that are addressed by these 14 bills. We cannot depend on the industry to please itself. Health care is as important for consumers as used cars, and we must look to government to protect our interest, even when it appears that this is not being done as effectively as we would like.

The bottom line for industry seems to be the bottom line. When the lives and the health -- when the lives and health of our members and consumers generally are at stake, that's not good enough. We are especially concerned that the health care needs of vulnerable groups such as the elderly, disabled, and low-income people may not be adequately addressed by the current system, and that your review will address this matter in your report.

Finally, I close by strongly urging that the work of this task force not be used as a pretext to prevent the current legislative reforms for the inactive. And I would hope you folks would support that position, because I don't think there's anything in the Patient Bill of Rights that's contradictory to what you folks are talking about today. Thank you very much.

(Applause.)

CHAIRMAN ENTHOVEN: Thank you. Steve Zatkin.

MR. ZATKIN: I agree with your last point about the role of this commission, but I wanted to ask a question because I'm a little puzzled. You said most of your members -- all of your members, I guess your seniors,

most of them are in managed care, but do you have -- unlike many of the folks in the commercial sector, they do have a fee-for-service option, Medicare, regular Medicare.

MR. POWERS: Many don't. Many don't. They come out of the kind of situations where they are retired Union members and they don't have options. They have to -- they have to be part of managed care systems or they're on -- they're on Medicare, and the choices that are there are governed by the cost of the systems that are there. So they --

MR. ZATKIN: It's the latter problem, because the cost-sharing would concern fee-for-service. So what is -- despite their concerns about managed care, they are still there because of the cost issue --

MR. POWERS: By the way, we're not here today to defend the fee-for-service system. We're here today, as the task force is set up to do, to talk about improvements in managed care. On one of the earlier speakers, I felt his position was diversionary, if anything.

MR. KERR: Thank you. Next speaker will be Lisa Merritt, Multicultural Health Institute.

MS. MERRITT: Hi, everybody that's left. I'm glad to see you all here, and I am very happy to be a part of this process and very honored. I am sorry that much of the task force has dissipated. I hope this is not a reflection of interest in the public, but more of everyone's busy schedules. I would like to make sure that

my comments get on the record.

First of all, I'd like to say that I am a specialist in physical medicine and rehabilitation. For those of you who don't know what that is, that is a physiatrist. There's a very small number of us in the country. We're unique in that we work within a multidisciplinary team concept. I think that it's a model that managed care can learn from in many, many ways. And that's part of what I'd like to speak to.

I have summarized ten main areas that I will be happy to submit to all members of the task force. There was very short notice that I received about this, and I have issued it to a few of the members, and I will be sending it.

The main areas I'd like to go through very quickly is the issue of access; the need for cultural competence and multicultural curriculum training; the need for research and useful data on outcomes and what we call outcomes, what types of outcomes; the need for collaboration amongst all the powers that be; the need for greater training of community health care workers and coordinators, as well as minority under served health care providers for under served populations and their inclusion in the health care plan and health care delivery; an effective plan of the 7 million or so uninsured people in California; a way to target education for an early and aggressive intervention strategy for high risk populations; the greater use of information technology,

and the greater need to bridge the gap between allopathic and complementary or traditional medical practice or spiritual medical belief systems.

I'd like to go into a little detail on each of these in the time remaining. First of all, for access, I think it should be very clear that we distinguish not just having insurance, not be assigned to a provider, because that does not relate -- reflect, you know, from my perspective in grass roots as a physician in practice. I'm speaking for my patients as having access. If that physician's office doesn't speak the language or doesn't have staff that are sensitive to their needs, that's not access. If that office is three bus rides away, there should be something in the questionnaire.

In the geographic managed care program in Sacramento, we had huge problems of people being shifted away from the doctor that knew them and their family to a clinic on a different part of town that they didn't know the bus route too. So the question that would be very useful, does your clinic have a bus stop that someone could walk from? That's very concrete information that I think would be helpful.

Do you have access to paratransit? My patient population have a lot of problems with mobility. They have to rely on whatever transportation there is for someone in a wheelchair. Paratransit has to schedule two weeks ahead of time or more in Sacramento. I don't know what that is in other places or if there's equivalent

resources.

Also, child care is a big issue in terms of access. We have people being assigned to plans where the mother has four kids and three of them are assigned to different pediatricians. So what does she do with the two other kids, because she can't take them to the doctor. This is the reality of what's happening. We have health -- we have child care in health clubs. I think that child care in a health clinic isn't too far fetched, particularly when it's an opportunity for health education.

The same thing tying into the issue of information technology. You don't need a big, fancy software program. I mean, in my office, we have information technology. You can use Microsoft Word, which all of these companies that have sophisticated computers to figure out how to negotiate and renegotiate the billing can certainly create electronic change; they can create educational profiles, and can have internet access right on site and show people who don't have that type of access, because not everyone does.

The multicultural curriculum is very, very important. Do we have to think of the demographic shift? This task force, this hearing right here is not reflective of California as it is today, and certainly not as California is going to be in the next 10, 20, 30 and 50 years.

Are we planning for right now a short

material stop gap measure, or are we looking in terms of strategic planning for an aging population, an extremely diverse population, among whom we know we have certain targeted health care problems like diabetes, hypertension, AIDS, violence, domestic violence. And are we prioritizing those health care problems with effective prevention programs.

Clearly from the data shown, just education in general about health is not being -- 3 percent or 4 percent. Just a few more things. In terms of the training and the collaboration, I had a chance to participate in a testimony in L.A. We worked four years to get that to happen in which we had at the same table at the same meeting community-based organizations, patient advocates, government agencies, legislative representatives, HMO representatives, academic institutions, and we talked about the same discussion you're having right here.

And what was interesting was everyone was really not that far apart. It's the perception. And that's what you're talking about, getting people in touch with their own perceptions and the perceptions of others and finding a place of respect to build interactions so you can build solutions.

And I think more of that needs to be part the process of not only this task force, but any health delivery system. You need to hear from all sides. Everyone needs to have a voice, because if you don't, it's

not going to be effective.

Look what's happened to geographic managed care. We need to have the patient input and we need to have the provider input into solutions on the system because some of them are very creative and not very expensive. Question?

MR. KERR: Questions? Yes.

DR. GILBERT: Thank you, Lisa, for coming. We're still here.

MS. MERRITT: I'm glad to see you.

DR. GILBERT: Couple questions. One is you've gone over a broad range of things, some of which I think are potentially amenable to market pressures. For example, in my area, they're not providers that speak Spanish in the health plan I'm responsible for, and in the other one there are. That could result in individuals making choices based on ability to have a language access. Which of the things you've talked about you think are more -- should be more regulated or organized governmentally? The regulation versus those that you think might respond to competition and market?

MS. MERRITT: Well, let me clarify the issue about competition and market. There's still a perception -- for example, in Los Angeles, the top three radio stations in terms of the population are Spanish speaking. But the price for advertising on those radio stations is only, like, $2,000 or $3,000 a minute, versus ABC, which is $7,000.

The perception is that that's not a market. So the perception still is, in many of these plans, this is not a viable market of people. And the perception -- and we have data research that there is often a very biased interaction for those patients in terms of their clinical outcomes, but they are the same ones that are going to have the highest risk and higher cost.

So I'm a little conditioned when we talking about market forces deciding that, because it still comes down from a decision-making process, and there are panels in Oakland that don't have one African-American provider. And Oakland is a 70 percent black population. You can't make that assumption.

That's why you need to have the multicultural training at all levels from the decision makers, legislators, HMO executives, the provider team, which includes the receptionist, the housekeepers, the nurses, anyone who comes in contact with the patient, and the patients on how to access that system.

So in terms of a solution, yes, I think you should have multicultural curricular training, because many people don't understand the needs of these different groups or the incredible disparities in terms of the health situations. And I think they don't understand that the issues of non-compliance, for example, can very much tie to communication problems.

If the person calls the office, and doesn't feel that they're being dealt with respectfully, they

don't go or they don't understand or they get lost, for example. In terms of what I think should be mandated, I think education --

MR. ZATKIN: Just to finish up, I agree with you on much of what you're saying. How do you make it happen?

MS. MERRITT: I think you need to have a certification process that's objective and that's verifiable. I think in terms of cultural competency, I think you need to make sure you have input from patients and patient representatives of all the different groups that are being provided to in part of the planning process.

And that's not something that's imposed on them. It's something that they are partners with. And that's part of the collaboration and partnership with the community that I'm speaking of, sharing resources.

And that even goes to why not have mentoring programs to begin to train trainers for community health care workers and community health educators? The HMOs would benefit from this to invest the money in the community and welcome them from a marketing standpoint.

And it also would improve outcomes because of improved education and prevention. So I guess I'm echoing the presentations earlier that there's not enough emphasis placed, and perhaps there needs to be some type of mandate that if they're using this money particularly, if they're managing Medicare and Medi-Cal, which are

public funds, then there should be some mandate to include in the use of those public funds effective education, as well as collaborating with existing traditional community health providers and collaborating with community educational processes.

MR. KERR: Another question.

DR. KARPF: I agree with you that we must face diversity of this state. It's a challenge and our greatest strength. I'd like to ask you your opinion. Is it more likely from your perspective that a tradition fee-for-service marketplace or a more organized marketplace, be it managed competition or some other level of organization, is more likely to be able to serve the needs of the culturally diverse populations who are particularly vulnerable populations?

MS. MERRITT: I think that it really -- I'm not making my point clear. I think the issue is the awareness of the system providing the care. I mean, historically, people of color, physicians of color have served those communities, regardless of whether there was Medi-Cal or Medicare or whatever.

What happened when there began to be public funds for that, other people started to serve those communities. So I think it's as much a matter of resources available, and I say this in all seriousness, I think it's more a matter of the opinion about these populations, because when you look at studies, for example, that compare cardiac care, even when the

insurance payment was not an issue, the type of care that was given was in complete reverse to the rate and the incidence and the severity of that disease process in those patient groups. In other words, black males did not get the aggressive care they should have gotten when they have the highest rate of incidence and mortality from cardiovascular disease.

So again, it's an education is what I'm speaking of. And I think the emphasis should be on education of whatever system, an education of the patients on how to access a system properly. Because they're used to, you just go to the doctor. Well, you end up going to the emergency room. You just deal with it until you're going to be dead.

And we have to change that mentality and get more into the preventive idea that you really do have access and people really do care about you and are going to take care of you, and how we bridge that perception from the patient side. And the perceptions from the provider's side is, well, this is a hopeless group of people. They're just too hard to deal with. They're too non-compliant. They show up late.

I mean, they're are so many things that come up that don't have to do with the health care process. It has to do with an interpersonal process. And people are often not aware of that. But it clearly is reflected in the type of care that's rendered and perceptions on either end of the scale when you look at the patients and you

look at the providers on that clinical interaction.

And one other piece I want to bring up that we didn't talk about was the whole influence of genetic identification of disease process and what it will mean in terms of long-term planning. What's going to happen when you have certain groups of patient populations that we know -- we already know historically have a predilection to these diseases, what are we doing when we know from eight that they're very likely to get diabetes or they're very likely to get cancer or both? How are they going to be figured in and be able to be covered in the future system? And what kind of mandate or responsibility should there be in the for-profit health insurance plan that really doesn't have those social obligations.

I'm asking you questions, but I'm trying to offer some solutions by saying we need to look at these things now and come up with useful strategies to deal with them. Otherwise, we will be having another task force in five years. Nobody wants to do this again.

MS. SKUBIK: Were you here for Dr. Legorreta's presentation this morning about the things they're trying to do to proactively do preventive care through sending disease management videos directly to patients? Did you hear that presentation?

DR. KARPF: I think that's a different issue. I think you're talking to an issue that systematically enables people to use a health care system and educates as opposed to a sporadic system.

MS. MERRITT: Yes.

DR. KARPF: And the reason I ask you that question is I wanted to see your bias as to whether you think a fee-for-service marketplace can actual respond to those kind of population needs, or whether in fact you need to have a more cohesive organized structure to be able to deal with those kind of issues in a way that's going to have reasonable efficiency.

MR. POWERS: Well, you know, I think it can be a combination of both. I as a practitioner see people in fee-for-service and managed care settings and for free. I got a check for $6.78. It was my 1099 from Medi-cal last year. And I hired a person to rebill on the new billing forms that they said we needed to use, because the previous billing forms were the ones they thought they were going to use, and then they changed their minds. And they still -- basically, I didn't get anything. I still had to pay that person several hundred dollars to try to do my backbilling. That's fee-for-service.

No, I don't think you couch it in those very basic terms. It's commitment. I do a lot of public speaking and education because I am committed and because of my training. And other physicians are like that who are committed. And I do a lot of education, and I could be a fee-for-service provider. It's more a matter of my own perspective on it. And I think a video is a nice idea. But what if that person doesn't speak English, or what if that person doesn't have a video machine?

I think most cultures bite a verbal human interface. A lot can be done with that. And I think training the trainer programs. One other piece that I want to emphasize is training the trainer programs. Community interface with the communities you serve, because you have these huge -- this dance, this one, that one, this one, that one. Everyone here has had probably two or three changes in their health care plan and possibly provider. So those relationships are being broken, and vulnerable populations are at risk.

I have populations right now that still e-mail me from across the country. My patients -- they're probably anywhere from 5 to 20 items long. I know them in my head like this. And for somebody else to try to take that person on their charts like this, and the time and the money it would cost that person to try to see them, you know, and to do something effective, it just doesn't make sense.

So I don't know if I'm making myself any clearer, but I will be happy to talk with any of you further. And I will be submitting a full report as well as some solutions that I have at other meetings.

MR. KERR: Thank you very much, Dr. Merritt.

(Applause.)

MS. SINGH: I just wanted to reassure our last speaker that we are transcribing the testimony that we receive today, and task force members will have access to this information.

MR. KERR: But in terms of commitment, this is the group. Our next speaker will be Dick Wexler.

UNIDENTIFIED SPEAKER: He left.

MR. KERR: He gave up. Okay. Sorry.

Sara Benjamin, as a Kaiser health plan member.

UNIDENTIFIED SPEAKER: She's here, but she passed.

DR. NORTHWAY: We've convinced her that everything is all right.

MR. KERR: Then we'll try for Betty Perry, who's from the Older Women's League.

MS. PERRY: The older women are enduring. My name is Betty Perry, and I'm the education and research coordinator for the Older Women's League of California.

At your last meeting, I arranged for a national report on managed care on older women to be delivered to you, and I think you have that. That was a national report. And today, I'm speaking more or less on local issues. And as I listened today, I heard some of you mention the value of advocates.

The Older Women's League is an advocacy organization. In the current legislative session, we are supporting the Patient Bill of Rights and particularly concerned about people being entitled to second opinions and care being -- and a problem of care being denied by health care managers instead of doctors. We think that doctors should determine the amount of stay a person

should have in the hospital after a mastectomy. And it shouldn't be an arbitrary time.

And in addition, I'd like to mention that in 1993 legislation was passed, which required doctors to provide osteoporosis testing. But many doctors and medical plans do not seem to even know about this today. We believe that managed care providers should look upon legislation as a real mandate for things that they're supposed to do. And we're going to continue to spread the word.

We feel that these -- the bills in the current session -- we hope that if they pass, we hope that the governor will sign them. And I liked Bill Power's suggestion that you not consider them in lieu of your report. But that's just kind of the beginning of things that we hope that you won't recommend. And we -- let's see.

And so my advocacy is kind of wearing out this afternoon. So with that, I will leave you. Oh, I know. The other thing I wanted to mention, we worked for breast cancer early detection, and we found that as advocates, we want to follow this legislation through, and we will be following your report through in the same theme.

(Applause.)

MR. KERR: Questions of Betty?

MS. PERRY: Remember that bone density testing.

MR. KERR: Next is Barbara Arnold. Dr. Barbara Arnold, California Association of Ophthalmologists.

MS. ARNOLD: Yes. Thank you. My colleagues have put me in the position of president elect of our state eye association, but I'm currently here as a patient advocate. I practice in the south part of Sacramento, where I'm probably the minority in my neighborhood.

About 60 percent of my patients have some form of managed care. I'd say between the many Medi's and the straight Medi-Cal and GNC patients, probably 43 percent have some relationship to the Medicaid program. And I will tell you there's no service code for seeing a patient through a translator. And I learned Spanish through my internship. There are so many people, the Mong, the Ming, the Pacific Rim, eastern Europeans, the Russians. We rely on a school age family member to translate or sometimes an employed adult child to translate over the telephone, but we do get a translation.

In an advocacy situation, I think the most important thing I want to bring up about access -- it doesn't mean you have a health plan. It means can you get to see a doctor in your neighborhood. A lot of people, walk, come by bus.

But when I found out from an elderly patient of mine who lives next door, who I hadn't seen in five years, and he said, "I just learned from these things going on in the Bee that I could disenroll from my plan

and get my straight Medi Medi back. I no longer have to spend 45 minutes and three bus rides to get to my doctor." He was so relieved that he could once again go to Medicare fee-for-service, Medi-Cal, and walk to a doctor on his block.

The broken relationships, I think, is the highest priority. I've been in my practice address, in my building for 16 years. Sometimes the patient will come back after a two or three intervals because they've changed health plans every year, and they'll tell me that they had M.R.I.'s and CTs and sought three or four referrals because under managed care, the doctor didn't really take time to listen to them, get a photocopy of their records, let alone read the copy of their records.

So they're constantly passed along like a hot potato. And had I retained that patient, I would have known that their loss of sight in that eye was extremely pre-existing for 20 years; that you don't have to spend more than a $20 office call to say, "things are okay."

And they get the multi-thousand-dollar workup because the new doctor doesn't know them. And if they did have the patient records, there's no way you can transfer the body of knowledge we know about somebody.

In addition to the body of knowledge, many times in a neighborhood office, we take care of parents, grandparents, aunts, and uncles. And we maybe know 15 people in the same family. And disease patterns often have great similarity among family members. And that's an

important body of information not to be lost.

Many people both employed and retired managed care programs deserve the option to pay a little more and get a PPO. But they'll say, "Well, my company only gives me two choices, and they're both HMOs. They will gladly take a little savings, pay a higher premium so they can do a fee-for-service style where they could chose the same doctors they've been accustomed to going to.

And then when they get a managed care doctor, they find out they have to wait maybe 2, 8, 12 weeks to see a doctor where there's many physicians at this time and throughout the state who have the capacity to see people the same day.

Someone earlier today had a question about, "Do you get to spend 15 minutes with your doctor?" I would like to say, "Do you get to talk to a physician?" Too many patients only get to see physician assistants or practicing RNs. And they're lucky if they get to see those if they've gotten through an advice nurse that's allowed them to get an appointment.

And then under some of the managed care programs for Medi-Cal, GNC, if I find a patient that's come to me, and they've got something serious like a paralyzed nerve or, say, optical nerve swelling, I'd called the referring practice back to see if I can get an M.R.I. or neurology consult because it's a special consult. I can't order those tests myself like I could under straight Medi-Cal.

But I'm told, "Well, there's not a doctor in today. Only the PA or only the nurse is seeing patients." And we have to wait until Monday or Tuesday until the practice has a physician because only the physician has the authority to order those more extensive tests.

And there's no mechanisms for keeping track of the vast number of people who pay out-of-pocket for services because they don't want to wait for a referral or spend 30 minutes on the phone trying to get a referral. They've got a job. They've got a family. They want an early morning appointment so they can be seen and get on.

So I have many patients who have their managed care plan for catastrophic coverage, but they want to pay because it's important they keep the same doctor/patient relationship. And I think the most sad thing is that patients are losing the right to choose.

(Applause.)

MR. KERR: Questions from the task force members?

Okay. Thank you very much.

MS. ARNOLD: Thank you.

MR. KERR: Have we missed anybody?

MS. PARSONS: I submitted, but I wanted to speak to it briefly. I submitted something. I also submitted a written testimony.

MR. KERR: Okay. Just come up and announce who you are.

Ms. PARSONS: I'm Dr. Margaret Parsons from

the California Dermatology Society. And many of you did receive the written testimony. I wish to address -- and I apologize for listing anecdotal and outcome. I had been told something that you wanted to hear those. And I apologize for that and just wanted to direct some specific comments. The reason I list some of those anecdotes, I think it's important in managed care to realize that very often patients have a very difficult time obtaining special referral when it is indeed important.

And I very often have patients coming in saying, "For six months I've been trying to get in here." And they've seen their primary care numerous times with expensive medications being used to treat when often a specialist can treat them more effectively. And I think it's important to consider that.

I am not here to say managed care is awful. I think managed care is mixed bag. There's a lot of good to it. Patients do have the ability to make some choices, and for many people it has been a more cost-effective means of having health care for seniors with limited incomes who aren't able to afford a secondary supplement insurance. managed care is not all bad.

I think it's also good in helping to have primary care physicians which do kind of coordinate a patient's care. I'm not here to say it's all bad and to fight for my specialty specifically, but I think it's important to emphasize that we need to allow for appropriate access for special referral to also prevent

elaborate authorization processes.

Patients with limited panels often come over an hour away to see me in my practice, and then due to the way the managed care is structured, I can't, you know, treat them that day. They have to come back another day after we've been able to retain referral, where they want copies of our notes, which, you know, you have to have dictations done, copying, and it's very elaborate. That is not cost-effective.

Patients are having to travel. People take off work in order to do that. Some are seniors who have to have one of their children take off work in order to bring them or people who have more difficult times traveling. It is an issue, and I would encourage you to look at the recommendation that you encourage people to look at appropriate special referral, and to help simplify authorization processes when someone is indeed being referred for something to be treated.

I also wanted to address briefly academic medicine, which is some of the information that I had received. You wanted me to address managed care's effect. I think it's important to look at how managed care is affecting training of our specialists. We must keep our specialists well-trained in order to continue to train specialists who will be able to treat people with the difficult, complex diseases, as well as to educate our primary care physician in basic knowledge of specialty diseases.

Dr. Lynch's report published in the archives of dermatology addresses not just dermatology, but all of medicine. And I think it is a good one and is worth reading and has a good summary of managed care's effect on academic medicine. Thank you.

MR. KERR: Thank you. Questions?

DR. GILBERT: Thank you for coming. You talked about appropriate referrals versus the process.

MS. PARSONS: Uh-huh.

DR. GILBERT: The process would theoretically be amenable to regulatory efforts. I'd like you to comment on that. But going to the first part, the appropriate referrals. I have read your examples really making the appropriate decisions referred to you prior to using multiple therapies on something that's, you know, not efficacious. Talk to me about how you think that issue can be addressed. And then secondly, if you agree around the regulatory approach to the process of referral.

MS. PARSONS: I think one of my concerns when I see someone coming in with a bag full of things tried, but are often very expense, is whether the primary care physician is someone receiving financial incentives for non-referral or whether there's restrictions on that managed care's group for regulation of referrals and how tightly are those primary physicians being regulated.

And to allow perhaps some laxity when they realize they're treating something that they don't know what it is, and they tell me, "Well, they weren't quite

sure. Try this. Try that." And to look at making sure the physicians are not restricted from referral when they are not comfortable or they clearly are not able to remedy a disease situation.

DR. GILBERT: How about the second term of the process?

MS. PARSONS: Authorization, I think there are some managed care plans. I treat patients from Medi-Cal -- different managed care groups as well as fee-for-service. Some of the managed care groups says "Here's something with this thing. Go ahead and treat it. Here it is." And one of the other groups says, "Only evaluation" when the primary care is written very clearly, you know, go ahead and treat these warts or go ahead and biopsy this obvious skin cancer. Or someone who is referred for a probable melanoma. When it's a melanoma, I have her authorization first and break what she's doing and get on the phone. I can't do that for everyone, or our patients will be sitting waiting hours while we try to process things.

MS. O'SULLIVAN: Can you talk to me about how the Medi-Cal authorization process feels different from referral process from patients who are coming to you through a private pay?

MS. PARSONS: When you say private pay, do you mean managed care or PPOs?

MS. O'SULLIVAN: Let's compare managed care. Medi-Cal managed care to private pay managed care.

MS. PARSONS: I would say some of the Medi-Cal I receive, they're just for one-consultation visits, which correlates with one of the major carriers, but yet some of the managed care groups say, "Hey, we realize this is something we're going to address. Go ahead and treat the condition."

Most of the Medi-Cal manage care programs is an evaluation. You have to have them back for further treatment. Some of them say you can treat. Again, they're very individual, and very often limited to one visit. One visits are frustrating, because when you initiate a treatment, you don't know how it works. So it's a very individual kind of thing.

So we have someone who spends her entire job getting referrals, making sure we have appropriate referrals for every single visit. And it can be very complex.

MS. O'SULLIVAN: Is Medi-Cal being way more --

MS. PARSONS: There's a variation. Some of the private pay are a little tighter, and some are more flexible. There's a spectrum in both.

MS. O'SULLIVAN: Thanks.

MR. KERR: Yes.

DR. ALPERT: I assume that you would agree that this task force made a recommendation to simplify the preauthorization process. What I'm interested in is if you have a specific recommendation to amplify that, to say

how to do that.

MS. PARSONS: I would say that when a patient is referred for a specific disease, that the specialist be allowed to carry through the full treatment of that disease, including the appropriate workup and such. One of the managed groups say up to so many dollars, you go ahead and do it. More than that, we need to know what's going on.

So there can be a guideline versus no, you have to ask for every single little thing. I think an authorization saying "we allow you to treat this disease within a spectrum of a certain amount" allows us flexibility to treat the patient appropriately.

The patient is less frustrated in being told they have to come back. And also the office is not as caught up in doing multiple amounts of paperwork, which has to be more costly not only to the practitioner but also to the managed group who is receiving the multiple pieces of paper.

DR. GILBERT: Can I just follow up on that? Two thoughts about dermatology. One is that in most cases when a PCP is referring to you it's either because he doesn't know what the diagnosis is or they thought they knew the diagnosis and the treatment didn't' work. So I would agree with you, there seems to be a vast majority of cases in dermatology that would be appropriate for referral that includes treatment. But I don't think that's true for many, many other specialty situations

where I'm trying to rule out a specific diagnosis, and then I want that patient to come back, because then I may send them instead to the neurosurgeon, I may send them to the orthopedic surgeon. I might agree with you, but not others --

MS. PARSONS: I would agree dermatology is somewhat different than other specialties. That is a caveat to specialty. In fact, two states have passed direct access legislation because we are somewhat different in the way some of our things are done.

MR. KERR: Dr. Merritt, do you want to come up to the microphone?

MS. MERRITT: I just want to make a quick comment on what she was saying. I think what you're also taking about in chronic conditions, in complex conditions, for example, I often will get a person referred for a consultation, and then what I will do is outline my full diagnostic impression and a suggested treatment plan. We do everything in-house. So as soon as I see the person, I fax the report over because I'm typing it.

They then know what the treatment plan is. And it's up to whoever decides it if they feel they want to follow through with that treatment plan as far as they can or if they need to refer back to me. So at least they get a full, kind of, look at what's going on. Most of the time, they kind of see where you're going. It's a coherent and justifiable process, and they're reasonable. They're going to go with you. What happens, if there's a

delay or playing around, you end up spending more money getting a complex and difficult thing to treat than if you go ahead and treat.

I'd like to back up with one of the comments. Dr. Susan Horne had done a pretty impressive study, I don't know if you've heard about it in other task force meetings, looking at HMOs across the country and looking at major health entities. It was about 15,000 people. It was a really big study.

And the bottom line was they found that if the physicians were allowed to do individualized and efficient care quickly in a timely manner, they actually saved money, particularly some of the more chronic and difficult conditions like asthma, et cetera.

And again, we come back to the multicultural populations, some of them, if they can go to the traditional providers and straight through, it makes more sense than to have to get to the primary doctor and not have to wait a week or two and have to go to the specialty doctor, where they might have to wait a few weeks or a few months even.

So by the time the specialist sees them, it's a much more complex situation, and it's harder to treat, and you have a worse outcome, and it's going to cost more.

And with regard to Medi-Cal, authorizations for Medi-Cal, there's a process called a Tar Process which involves these incredible forms. Now, I can talk about

Medi-Cal and Medicare all day long, but I'm not gonna.

DR. GILBERT: It's important, because the Tar for Medi-cal is the fee-for-service, not the managed care.

MS. MERRITT: I totally agree. And that's what I was going to point out; that depending on which system the person is in, the problem is even with Medicare, you still have to document -- if you have people with a chronic condition that you know is not going to change, and they're going to need a wheelchair, let's say, or whatever it is they're going to need, you still have to fill out these incredibly redundant forms, which cost time and money.

And one other solution that I would like to suggest is a universal form for disability, for authorization, for summary of the problem, and for medications, because it's the same information.

Now, my population -- for one patient, I have to do forms for state disability, forms social security, forms for Medicare, forms for the unemployment, forms for their employer, forms for the D.M.V. I mean, ten different forms literally, and each one asks the same questions.

One form, universal form, would save so much money for a lot of physician's offices and improve the efficiency with which people can be processed. And that has come up before. It's not an impossible concept. And it may not seem an important one, but in terms of

improving the flow, I can tell you, I can get rid of half a person just for form time alone.

DR. ALPERT: I can't resist. You really hit something. You said it's not hostile -- it may not seem important, but believe me it is. I'm paraphrase. And I think that that phenomenon exists a lot in the problems that we're facing. I think there are components just like the one that's just been discuss. And that's why I was hitting on preauthorization also. It's all part of the same thing.

There are problems that are not perceived by everyone looking at this, because they're often different -- there are very few of us, to be quite frank, who are in doctor/patient relationships on a daily basis. Those of us who are, and there are three of us right now at this table, realize that these things which may seem tiny are huge in impact in terms of cost, time, energy, efficiency, and doctor/patient relationship, et cetera.

And I hope that we're finally getting into sort of finding that out. And maybe we'll chew on it, and flush it out, and something will come of that component. Because it's a huge component.

MR. KERR: Thank you. Any questions? I'll take one more from the audience.

MS. MERRITT: Get the other doctor up here.

MS. ARNOLD: For the record, I'd like to exemplify the common problems with dermatology and ophthalmology. We'll have a mother take a child out of

school because they have a swollen lid, inflammatory. It's so unsightly and so deforming that you push on the outside and cause a refractory change. They want it drained. But geographic managed care won't give authorization for diagnosis. The GPs have already figured out the diagnosis, but we have to bring them back a week or two later after we get an authorization. And authorizations are passed out only once a week. So we have grandma in with glaucoma. You need a working employed person to bring grandma in, but you don't have the authorization to take the necessary optical photo, to do the visual fields.

And if there's high pressures and visual field laws, you got two out of three indicators. We can go ahead and start treatment that day. But you have to withhold treatment for several days, because it's one day at a time, very piecemeal. You can do one piece, and you can only get an authorization for one thing at a time. And there's such an efficiency if you can do it all at once.

MS. O'SULLIVAN: Do you see Medi-cal managed care patients?

MS. ARNOLDS: A lot, yes.

MS. O'SULLIVAN: How do you see that compared to your private paid managed care?

MS. ARNOLDS: Or even could I compare it to, like, straight Medi-Cal, is there really efficiency there, where as the geographic managed care, you can't do

anything without an 11 digit authorization number, and you have to wait a few days to get it by fax. Sometimes you can get it the morning after.

MS. O'SULLIVAN: How about compared to private pay managed care? Is it way more difficult?

MS. PARSONS: Well, some plans -- they're very similar. When I entered this town, I could run my office with one and a half full-time equivalents. Now it takes about four full-time equivalents. The paperwork used to get managed one day a week. Now it's a two-person five-day-a-week job, I'm not seeing more patients, but I'm paying much higher wages for the paperwork shuffle.

MS. RODRIGUEZ-TRIAS: I wanted to ask because since in the whole -- managed care is the cost in payment because of these controls, if you will, to over utilization or whatever. What's the answer? Is there possibly advice for people who have certain conditions?

MS. MERRITT: Yes. This is what I was speaking about when I was talking about targeting high risk populations. There should be some kind of fast track so people don't get caught like this and run into -- I mean, especially when there's such a serious outcome such as loss of vision, which I have seen also. And loss of function, which I have seen also.

There should be a fast track. We have a priority person. And in part, again, it is education, because who is making the decision often. The decision is being made by someone you have to spell out the diagnosis,

and that is not only infuriating at times when you're exhausted and trying to do the right things. It's very frustrating when you as a physician understand the severity of a situation, and trying not to sound like you're just trying to, you know, get your Porsche payment. You're trying to get this thing done for the patient.

And you're having to reason with a system that the way sometimes it's structured is very irrational, because you also know their goal is try to save money.

And it's a matter of prioritization and education, you know. If you have a diabetic, hypertensive patient that has classic signs and symptoms, that person needs to be fast tracked. Like the other person said, Kaiser didn't have the medical assistance. There's a problem with that. There has to be a certain quantity of the people, you know, making the decision and a system to educate so that there's a prioritization or triage, if you will, and to understand the outcome.

Going back to Susan Horne's data. If you give people what they need, go outside and institute formulas for certain patient groups because it's going to work better or they're going to be more compliant, you're going to end up having better outcomes and you're going to reduce costs in the long run.

MR. KERR: Any other questions? Rodgers.

MR. RODGERS: Based on what you're saying, what you're describing is what I call hassle factor. Hassles of getting them in for care.

Do you think the poor performing managed care plans will be weeded out in the long term? By long term, I mean next three to five years, or that there has to be legislative initiative cause, raising of the bar, consistent raising of the bar?

MS. MERRITT: I would say without legislative initiatives, I would probably move out of this country. I could go to Jamaica, and I would have better prenatal morbidity mortality rate than right now as an African-American woman if I were to have a baby in America.

There's something terribly wrong with that. And there is no incentive. And what's happening now is with vertical integration, which we're at in Sacramento, you're not even dealing just with capitation. You're dealing with an entire infrastructure that has now grown like a cancer that's just totally solidified and organized itself. And the whole impetus is leaving out the people in the process, the providers, namely the provider teams and the patient. And it's often not even based on rationality. It's based on a concept that was set forth, and it's kind of going on its own now.

And you see people shunted, and they're not looking at the whole picture. There's not enough time. Everyone is pressed for time. There's more errors being made. There's going to be more liability. But who's going to suffer in the end? The only one I care about is the patient. The patients are going to suffer.

So legislative input to say there has to be accountability, this, this, and this in terms of where the money is being spent, how much education is being made, how much community collaboration is there, how much targeting of high risk populations, what really is compliance ratio, and are you getting -- I mean, I have patients who do pay out of plan to come see me.

I have to literally write -- not only write letters, but get on the phone with their physicians in their delivery systems. I'm not even trying to yell at the -- they're paying me cash. I'm not even involved in it. And I can't even convince them to treat high blood pressure that's not being treated properly, to get the diabetics under closer control.

Diabetes in my family -- for example, all my first cousins have it, except for the last one that was just pregnant. She couldn't get into a birthing class, even though her plan advertised that they have prenatal birthing classes. She's 35. She's high risk. Her sister just had an 11-pound baby and was diabetic. And I'm saying you have to get into birthing class. They have to follow you carefully. They need to do additional tests. She was growing huge quickly, all the signs of early diabetes, and she couldn't get in to be seen any faster, get any closer attention through that system that advertised it having these things in place.

And I'm not in that system. So what I'm saying, it's a conceptual framework we're talking here.

It's beyond the hassle factor, the authorization process. And I think, you know -- I'm going to let you speak too -- I think legislatively we're going to have to look at certain standards of care. Not define quality as how long they have to wait or how long before they get an appointment with a warm body or how much they save or how much they go down in their premiums.

Quality needs to be defined by effective outcomes, amount of people who are educated, changes in health behaviors, those kind of things, which I think this survey is going to be important.

MS. PARSONS: I would address when you said the types of plans that are more onerous, I believe that word has been used, are some of the larger ones. Or the one I particularly get more frustrated with is one of the larger groups. You have to remember that the large HMOs, it's also -- it's a business driven thing, and the large employers are choosing that which is most cost effective.

So long as that HMO continues to be cheaper, that employer may continue to contract with that organization. And until there are requirements for employers to provide more than one plan, provide a PPO plan, those more tightly regulated type HMOs, regulated meaning they control cost factor and are more onerous to deal with, those HMOs I think will continue to exist.

It's a business thing not only from an HMO standpoint, but also from all of our large employers in our state. So it's not a new issue.

MR. KERR: Any other questions? Fascinating afternoon. Did we miss anybody else? I want to let you know if you would like to submit written testimony, contact one of the task force members. The next hearing is in Los Angeles, Thursday, August 7. Thank you very much for your time, especially on Saturday. And I declare this meeting closed.

(Whereupon the proceedings were adjourned at 4:46 P.M.)

STATE OF CALIFORNIA)
) ss.
COUNTY OF SACRAMENTO)

I, SERENA WONG, RPR, CSR NO. 10250, a Certified Shorthand Reporter in and for the State of California, do hereby certify;

That said proceeding was taken down by me in shorthand at the time and place named therein and was thereafter reduced to typewriting under my supervision;

That this transcript contains a full, true, and correct report of the proceedings which took place at the time and place set forth in the caption hereto as shown by my original stenographic notes.

I further certify that I have no interest in the event of the action.

EXECUTED this 29th day of July 1997.

SERENA WONG, RPR, CSR NO. 10250